Connecticut Department of Social Services

Making a Difference

Written Testimony before the Aging Committee

February 25, 2016

The Department of Social Services offers the following written testimony on several bills that impact the agency and its programs.

S.B. No. 162 (RAISED) AN ACT CONCERNING A COMMUNITY SPOUSE'S ALLOWABLE ASSETS

This bill proposes to allow the spouse of an institutionalized person who is applying for Medicaid (referred to hereafter as the "community spouse") to retain marital assets up to the maximum allowed under federal law, currently $119,220.

Under current statute, community spouses of long-term care Medicaid recipients are allowed to keep one-half of the couple's liquid assets up to the federal maximum of $119,220. If the total of the assets are under $23,844, the minimum allowed by federal law, the community spouse may keep all of the assets. The couple's home and one car are excluded from the assessment of spousal assets. The federal amounts may be adjusted annually based on increases in the Consumer Price Index.

The Department maintains that the current policy, which has been in place since 1989 (with the exception of FY 2011), is fair and reasonable. The existing policy supports the original intent of the 1988 Medicare Catastrophic Coverage Act -- to prevent the impoverishment of spouses of those applying for Medicaid coverage for long-term care. Furthermore, the department's current policy is in line with most other states.

Today, as in past years, we cannot support increasing the minimum Community Spouse Protected Amount because it will have a significant negative fiscal impact on the Medicaid account in this challenging budget environment.

S.B. No. 164 (RAISED) AN ACT CONCERNING MEDICAID COVERAGE OF TELEMONITORING SERVICES

This bill requires the Department to add telemonitoring services to the Medicaid State Plan as an optional service. The Department does not anticipate an increase in Medicaid funding that would enable us to add telemonitoring to existing nurse and home health aide services, and therefore cannot support this legislation.

The Department hesitates to endorse telemonitoring as a means to achieve savings because previous home health reforms (i.e. nurse delegation and med-boxes) enacted to reduce costs have not yet proven to be successful.

For these reasons, the Department must oppose this bill.

H.B. No. 5283 (RAISED) AN ACT RESTORING STATE ASSISTANCE FOR MEDICARE PART D BENEFICIARIES

This bill requires the Department to pay on behalf of dual eligible, Medicaid and Medicare Part D enrollees, drug copayments that exceed $15.00 per month in the aggregate. Prior to FY 2016, Connecticut was one of only a few states assisting dually eligible clients with the cost of Medicare Part D copayments, which range from $1.20 to $7.40; under the Affordable Care Act, dually eligible individuals who are receiving home and community-based services under Medicaid are not responsible for any copayments. Restoring this benefit will require an additional appropriation of approximately $140,000 in FY 2017, plus additional costs for systems changes to accommodate this service and administration of the benefit.

Given the current difficult economic climate, the Department is unable to support this bill.

H.B. No. 5284 (RAISED) AN ACT INCREASING FUNDING FOR ELDERLY NUTRITION

This bill will increase the rate paid to providers that deliver meals to the homes of individuals that participate in the Connecticut Home Care Program for Elders (CHCPE) and minimize any co-payments for recipients. Specifically, it requires DSS to increase the fee schedule for meals-on-wheels under CHCPE to cover "reasonable costs" of providers. The bill also requires DSS to annually increase the fee schedule for homemaker services, chore person services, companion services, respite care, meals-on-wheels, adult day care services, case management and assessment services, transportation, mental health counseling, and elderly foster care based on increases in the cost of those services.

This bill will result in significant additional costs. Operationally, it would be difficult to have differential rates depending on the population served and, from a policy perspective, it is not recommended. On January 1, 2015, the department increased home care rates by 1% at an annualized cost of approximately $7.3 million (before federal reimbursement). This cost of living adjustment was applied to all of the waiver populations as well as home health. Although "reasonable costs" are to be based on the cost of food, food preparation and packaging, transportation, delivery and associated labor and administration costs, it is difficult to quantify these costs or the cost of the increase in rates to reflect the increases in the cost of services. Nevertheless, it would not be unreasonable to assume over $15 million in costs to the Medicaid program (before federal reimbursement) plus over $1 million in costs to the state-funded Connecticut Home Care Program in the first year of implementation, with costs increasing each year to reflect increases in service costs. In addition, lowering recipient co-payments is projected to cost an additional $750,000 in FY 2017.

In addition, while the Department certainly values the work community providers deliver to beneficiaries of our programs, there are multiple services and hundreds of providers participating in not only the Connecticut Home Care program, but other waiver and community-based services programs. The Department believes singling out one provider type at the exclusion of the others is inequitable and cannot be supported.

Given the current difficult economic climate, the Department is unable to support this bill.

H.B. No. 5286 (RAISED) AN ACT CONCERNING LONG-TERM CARE

The Department of Social Services commends the Aging Committee for its attention to the need for strategic planning for Medicaid long-term care services. This is a critical need given the strong preferences of older adults and individuals with disabilities to live in home and community-based settings, the state's interest in controlling escalating costs, and support for town-level tailoring of strategies to meet local needs. DSS respectfully states that this legislation is not needed.

In keeping with the legislation enacted by the General Assembly, Governor Malloy, the Office of Policy and Management, and DSS released the Strategic Plan to Rebalance Long-Term Services and Supports. The strategic plan captures the data and planning strategies that are contemplated by this bill. Also, Connecticut General Statutes section 17b-337 requires the Connecticut Long-Term Care Planning Committee to prepare a long-term care plan every three years based on the fundamental principle that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting. The most recent

plan, entitled Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut, was recently released in January of 2016.

H.B. No. 5287 (RAISED) AN ACT CONCERNING MEDICAID ELIGIBILITY FOR HOME-CARE SERVICES

This bill would provide retro eligibility coverage for applicants for the Connecticut Home Care Program for Elders (CHCPE). While the Department is committed to working on initiatives that ensure timely services to those in need of home care services, as evidenced by the initiation of a "FastTrack" pilot program in July 2015 for applicants of the Home Care Program for the Elderly (CHCPE) waiver, we cannot support this proposal at this time.

Although the Department shares the desire for individuals to obtain prompt access to home care services, we do not believe this proposal can be operationalized given the current allocation of resources and processes for determining eligibility. Furthermore, we believe this will require additional financial, administrative and staff resources.

The Fast Track pilot determines potential eligibility for new applicants for the state funded portion of the CHCPE within two (2) or three (3) business days of identifying them as Fast Track eligible. The Fast Track process reviews a client's application and determines if they meet the criteria for Fast Track. This is done through questions related to the applicant's assets and income. If Fast Track eligibility is approved, and the applicant has completed a functional assessment confirming functional eligibility, the applicant may begin to receive state-funded home care services.

It is important to note that Fast Track applicants still are required to comply with all standard Medicaid Waiver application procedures to determine eligibility for the Medicaid-funded component or to validate eligibility for the state-funded component of the program. Also, when Fast Track eligibility is granted, clients are notified that if they subsequently are found ineligible for Medicaid they will be responsible for their share of the state funded benefit. At that time, the applicant may reject Fast Track services and wait until the application is reviewed for complete Medicaid coverage, which may take up to 90 days.

Although, the Department is pleased with the preliminary results of the pilot, more time is needed to review outcomes and to address potential challenges and improve overall service delivery.

H.B. No. 5289 (RAISED) AN ACT CONCERNING PROTECTIVE SERVICES FOR VULNERABLE PERSONS

Section 1 - This section requires the Department of Social Services to develop a strategic plan to incorporate the Administration for Community Living's (ACL) national guidelines into protective services offered to adults sixty years of age or older in the state.

This section is an important step to ensure the Department is applying consistent best practices and uniform guidelines to our protective services for the elderly. The Department is committed to ensuring that our protective services are done with the highest quality of care. As the Department has seen a large increase of protective services referrals over the last few years, we understand the need for consistent strategies to address these growing needs.

In response, the Department is currently in the process of incorporating both the ACL guidelines and aligning the state data collection with the National Adult Maltreatment Reporting System, in the Department's Social Work division's protocols and policy. As the Department has already begun to embark in this process, the Department believes section 1 of this legislation is unnecessary.

Section 2 – This section requires the Commissioner of Social Services to develop an educational training program to support the correct and timely identification and reporting of abuse, neglect, exploitation, and abandonment of elderly persons. The training program is required to be available to mandated reporters and other interested individuals on the public website of the Department of Social Services, along with in-person trainings at various times and locations throughout the state.

The Department is also already in the process of creating an online training program for mandated reporters. We expect to have this training available by the end of 2016. In addition, the Department already offers in-person mandated reporter training upon request. For these reasons the Department respectfully believes that the section 2 is also unnecessary.

Sections 3 and 4 – These sections require the commissioner to disclose certain information to persons who reported suspected abuse, neglect, exploitation or abandonment of the elderly and those in long-term care facilities. If the bill is to move forward, the Department respectfully requests that the following changes are made to the current proposed language:

Section 3: Sec. 3. Subsection (a) of section 17b-452 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2016):

(a) The commissioner, upon receiving a report that an elderly person allegedly is being, or has been, abused, neglected, exploited or abandoned, or is in need of protective services, shall investigate the report to determine the condition of the elderly person and what action and services, if any, are required. The investigation shall include (1) an in-person visit to the named

elderly person, (2) consultation with those individuals having knowledge of the facts of the particular case, and (3) an interview with the elderly person alone unless (A) the elderly person refuses to consent to such interview, or (B) the commissioner determines that such interview is not in the best interests of the elderly person. If the commissioner determines that a caregiver is interfering with the commissioner's ability to conduct an interview alone with the elderly person, the commissioner may bring an action in the Superior Court or Probate Court seeking an order enjoining such caregiver from interfering with the commissioner's ability to conduct an interview alone with the elderly person. In investigating a report under this subsection, the commissioner may subpoena witnesses, take testimony under oath and compel the production of any necessary and relevant documents necessary to investigate the allegations of abuse, neglect, exploitation or abandonment. The commissioner may request the Attorney General to petition the Superior Court for such order as may be appropriate to enforce the provisions of this section. Upon completion of the investigation, the commissioner shall prepare written findings that shall include recommended action and a determination of whether protective services are needed. The commissioner may disclose, in general terms, the result of the investigation to the person or persons who reported the suspected abuse, neglect, exploitation or abandonment, provided: (i) the person who reported the abuse is legally mandated to make such report, (ii) the information is not otherwise privileged or confidential under state or federal law, (iii) the names of the witnesses or other persons interviewed are kept confidential, and (iv) the names of the person or persons suspected to be responsible for the abuse, neglect, exploitation or abandonment are not disclosed unless such person or persons have been arrested as a result of the investigation.

Sec. 4. Subsection (g) of section 17a-412 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2016):

(g) The person filing a report or complaint pursuant to the provisions of this section [shall] may be notified in general terms of the findings of any investigation conducted by the Commissioner of Social Services [, upon request] not later than thirty days after the investigation is completed, provided: (1) the person who reported the abuse is legally mandated to make such report, (2) the information is not otherwise privileged or confidential under state law, (3) the names of witnesses or other persons interviewed are kept confidential, and (4) the names of the person or persons suspected to be responsible for the abuse, neglect, exploitation or abandonment are not disclosed unless such person or persons have been arrested as a result of the investigation.

Section 5 – This section requires the Commission on Aging to evaluate the current protective services program for elderly and to make recommendation concerning expanding protective services to persons 18 years of age or older. In recent years, DSS has struggled to live within the available funding for the Protective Services for the Elderly program, which serves persons 60 years of age or older. Expanding Connecticut's protective services system is not feasible in this economic climate and, given limited resources and competing priorities, the Department would

not be able to implement recommendations from this proposed study that involve such an expansion.

H.B. No. 5290 (RAISED) AN ACT INCREASING FINANCIAL ASSISTANCE FOR GRANDPARENTS AND OTHER NONPARENT RELATIVES WHO ARE RAISING CHILDREN

This bill would increase the payment standard for child only assistance units in the Temporary Family Assistance (TFA) program to seventy-five percent of the foster care rate paid by the Department of Children and Families.

While the Department appreciates the goal of achieving equity in these benefits, we estimate the cost of such a change to be approximately $11.625 million. Therefore, we must oppose the bill due to the significant costs associated with providing such a benefit increase.